A Letter from the Director,
Missouri Department of Health

Dear Missourians:

It is my pleasure to share with you information regarding managed care plans provided by Missouri managed care providers. The Missouri Department of Health has worked hard to gather comparative information regarding managed care services and present it in a timely and understandable manner. This document is meant to help educate consumers and provide information that will better enable all Missourians to make informed decisions regarding their health care.

The *Buyer's Guide: Managed Care Plans* provides information that will enable you to compare managed care plans. In partnership with your physician, you now have information with which to make informed decisions about your health care.

I encourage you to take the time to use this valuable resource to its full advantage.

Very truly yours,

Index

Section

How To Use The Guide

As part of its mission to protect and promote the health of Missourians, the Department of Health (DOH) is pleased to issue this consumer's guide to managed care plans. The guide's primary objective is to assist health care consumers and purchasers in making informed choices regarding managed care options through reports on the quality of care, access to care and member satisfaction with managed care plans that provide services in the state of Missouri. As more Missourians enroll in managed care plans, it is important that they have the most reliable information currently available on managed care plans operating in our state. If you are already enrolled in a managed care plan, this guide can help you evaluate the performance of your plan compared with other plans. If you need to make a choice between managed care plans, the guide can help you compare various plans.

All managed care plans were given the opportunity to review their own information. Their comments, any difference between our information and theirs, and the actual data and the statistical formulas used for the analysis are contained in a second volume technical report. It is available from the Department of Health for $10.

Comparing managed care plans can be a complex and difficult task. The indicators used in this report should be viewed in combination and are intended to assist consumers in developing a list of additional questions for providers. No one indicator should be isolated outside of this context. Consequently, no one "number" or "indicator" in and of itself is a direct measure of the quality of care provided. This consumer guide should not be used to rank managed care plans. However, it does identify a number of criteria by which Missourians can assess their managed care options so they can make the best choice for themselves and their families. In this report we use nationally accepted indicators, surveys and methods from such groups as the Health Care Financing Administration, the Missouri MC+ program, and the National Committee for Quality Assurance (NCQA) and its Health Plan and Employer Data and Information Set (HEDIS®).*

We recognize that development and release of consumer data both in Missouri and nationally is in evolution. However, there is a national consensus that public data disclosures are in the public interest.

To continually improve our service to Missourians and to reflect the developing science of consumer reports, each release will be reviewed to determine how to enhance subsequent releases.

Consumers have a right to know as much as possible about the services provided by health care providers and the outcomes of care. Indeed, an informed consumer will be a more active, responsible participant in his or her own care. As such, consumers empowered with information may become not only more responsible for their own care but also better partners with their health care providers. These conditions may in turn prove to be beneficial to the future health status of Missouri's citizens.

There are three volumes in this year's report: one report for each region of the state - eastern, central and western. Also, because of the differences in coverage and services provided by commercial, Medicare and Medicaid managed care firms, each of the three regional reports contain a section on each of these types of plans.

* HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

The Missouri Department of Health has attempted to publish accurate information based upon common definitions. Providers were given an opportunity to review and correct data that seemed in error. It is possible, however, that some corrections were not received. If you believe that this publication contains an error, or if you have a suggestion about how to improve future publications, please contact the Center for Health Information and Epidemiology, Missouri Department of Health, PO Box 570, Jefferson City, MO 65102. Our telephone number is (573) 751-6279. Contact the Missouri Department of Health for additional copies of this report at $3 each.

The Missouri Department of Health is an equal opportunity/affirmative action employer. Services are provided on a nondiscriminatory basis. This information is available in alternate formats to citizens with disabilities.

What Do We Mean When We Say . . .

The following terms and definitions, as well as those throughout this guide, are provided to help consumers understand this guide's concepts.

Managed Care Plans

This term is used to refer to a variety of different types of managed care service products from traditional plans with large networks of participating health care providers to HMOs with a very limited number of providers. Between these two are a wide variety of hybrid plans including point-of-service (POS) plans. Commonly, managed care plans attempt to provide greater coverage for less or no more cost than traditional indemnity fee-for-service plans by "managing" enrollees' health care through a primary care provider.

HEDIS

Health Plan Employer Data and Information Set (HEDIS) is a core set of performance measures initially developed to respond to an employer's needs "to understand what 'value' the health care dollar is purchasing and how to hold a managed care plan 'accountable' for its performance." Although designed for the employer's use in selecting managed care plans for their employees, HEDIS has been used or adopted in some form by other groups to compare alternative care options in the primary care setting.

HMOs

"Health Maintenance Organizations" are organized health care systems that finance and deliver a broad range of comprehensive health services to an enrolled population. The term is often used to include the aspect of financing health care for a prepaid fixed fee (prepaid health plan), but that definition is no longer absolute as there are a variety of types of plans. There are five general HMO models, including: staff, group, network, IPA and direct contract.

Indicator

An "indicator" describes an aspect of health care delivery that may be measurable compared with clinically valid criteria at the local, regional, state and national level. Indicators provide an "indication" of the quality and appropriateness of care or "indicate" how good care may be. Indicators should be reviewed prior to making a decision or enrolling in a managed care plan.

Primary Care Provider

Managed care plan providers are grouped in two categories. The first category, "primary care provider" (PCP), is a primary care physician or nurse practitioner who provides basic services or "first line" care. They are also responsible for well-person care and preventive care to managed care plan members. The PCP may be the only provider a member needs to visit in order to complete all their health care check ups.

PCPs have another important function. They coordinate care provided by the second category of providers, referred to as "specialist." Specialists are physicians who have additional training in the management of special health care needs such as major surgery or complicated cardiac care.

The choice of a PCP is vital to consumers, and managed care plans recognize the importance of this doctor/patient relationship. Many managed care plans are allowing women to have the choice of well-woman care with a gynecologist. In other cases, diabetic patients may be permitted to have an endocrinologist assume the primary responsibility for the coordination of care.

In most cases, consumers should designate a provider who is their primary resource and "first" contact. When a member enrolls in a managed care plan, the PCP should be identified and selected from the list provided by the managed care plan.

Accreditation

Two national organizations accredit health plans in Missouri: The National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC). Accreditation is important because it indicates a health plan has met national quality standards.

Commercial, Medicare and Medicaid Managed Care Products

Consumers can select a managed care plan based on qualifications such as age and income. *Commercial products* are available to consumers and employees based on ability to pay premiums. In most cases commercial products are selected by employers for consideration by their employees as part of their benefit program. The *Medicare products* are available to those who meet the age qualifications (age 65 and older) or disability requirements for Medicare insurance coverage. *Medicaid products* have been developed in the state of Missouri to meet the health care needs of those who meet its financial and/or disability eligibility criteria.

Quality

Quality is defined as the extent to which care provided meets nationally recognized standards of care. The answers to the following questions help to determine the extent to which there is quality care.

Are the appropriate services provided to the right person, at the right time and in the right setting? How does the managed care plan "measure up" in terms of the technical and interpersonal aspects of care?

Member Satisfaction

Member satisfaction is an important dimension of quality from a managed care plan member's perception. The answers to the following questions help determine both if satisfaction exists and the level of satisfaction.

Are current plan members (especially those who use services) satisfied with the care provided? What is the level of satisfaction?

After reviewing what many national experts recommend as useful for understanding managed care plans, a committee representing consumers, health plan representatives, physicians, nurses, health department representatives, insurance department representatives and purchasers recommended the indicators used in this report.

Where Did We Get This Information?

We show information on services and quality of care in this report to help consumers select the best managed care plan to meet their needs. The information comes from a variety of sources including:

- NCQA member satisfaction survey conducted by independent survey firms;
- National managed care averages are from NCQA's 1998 Quality Compass ™ report;
- Health Care Financing Administration (HCFA) member satisfaction data collected by this federal agency which is responsible for administering the Medicare program;
- MC+ member satisfaction survey conducted by the Division of Medical Services;
- Birth certificate data maintained by the Department of Health;
- HEDIS® data submitted by Missouri managed care plans and audited by independent NCQA licensed firms;
- Financial data collected by the Department of Insurance;
- Enrollment data supplied by the plans to the Department of Insurance;
- Disenrollment data submitted by the plans to the Department of Health.

What Have We Learned About Managed Care?

There is a joint responsibility among managed care members, physicians and plans to assure utilization of preventive services such as mammograms, Pap smears, diabetic eye exams and immunizations. However, there is an under-utilization of such services among managed care members. There are no comparable data for persons not enrolled in managed care.

Fifty-eight percent of persons enrolled in commercial managed care were satisfied or highly satisfied with their managed care plan, compared with the national managed care average of 57%. For other questions that we reviewed, Missouri commercial managed care respondents were also similar to national respondents.

Of the satisfaction questions reported in this guide, the highest level of satisfaction was shown for respondents indicating no problem in receiving care needed (85%). The lowest satisfaction rating was for the question on the number of doctors from which they could choose (39%).

Managed care members who had seen a doctor or had been in a hospital recently generally indicated higher satisfaction with their managed care plan than members who had no recent medical treatment.

Although members of Point of Service (POS) plans have fewer restrictions, they generally do not report a higher level of satisfaction than other managed care members.

Pregnant women in managed care plans were more likely to receive care in their first trimester of pregnancy than women not in managed care plans (95% vs. 89%). However, women in Medicaid managed care plans were less likely to receive early prenatal care than women in commercial managed care (67% vs. 95%) plans.

The cesarean section rate is the same for women in commercial managed care and those not in commercial managed care (21%). The 16% Medicaid managed care cesarean section rate is closer to the national goal of 15% than the commercial managed care rate.

Sixty-six percent of women age 52-69 in commercial managed care plans received a mammogram in the past two years while 68% of women in Medicare plans received the screening. This is lower than the national managed care rate of 71%.

Twenty-eight percent of diabetic persons in Missouri commercial managed care plans received an annual eye exam from their physician. For Medicare diabetic patients, the annual eye exam rate was 42%. This compares with a national managed care rate of 39%.

Fifty-seven percent of commercial managed care and 50% of Medicare managed care patients hospitalized for a mental health condition received a follow-up visit within 30 days.

An average of 7% of two-year old children were immunized within the recommended time frame according to the Medicaid managed care plans that had reportable data. The state immunization rate is 78% and the U.S. public health goal is 90%.

Thirty-three percent of women in Medicaid managed care received a Pap test for cervical cancer in the previous three years. The U.S. public health goal is 85%.

Sixty-four percent of smokers in managed care plans reported they were advised by their physician in the past year to quit smoking. The U.S. public health goal is 75% or more.

Plans with High and Low Performance

The following pages list those health plans by managed care plan type (commercial, Medicare and Medicaid) with statistically significant higher than average performance and lower than average performance for selected indicators. These three charts summarize the more detailed data found on pages 12-17 of the report and may serve as a ready reference for the reader.

Commercial Managed Care Plans with High or Low Indicators

	Central Region	
	Managed Care Plans with	
Indicator	Higher than Average Performance	Lower than Average Performance
Rate of Prenatal Care in First Trimester	BlueCHOICE, Group Health Plan, Healthlink, Humana Health Plan, Mercy/Premier Health Plans, Prudential HealthCare Plan, United Healthcare of the Midwest	
Cesarean Section Rate	Mercy/Premier Health Plans, Missouri Advantage	BlueCHOICE, Group Health Plan, United Healthcare of the Midwest
Vaginal Birth after Cesarean Rate (VBAC)		
Breast Cancer Screening Rate	Group Health Plan, Prudential HealthCare Plan	BlueCHOICE
Diabetic Eye Exam Rate	Group Health Plan, Health Partners of the Midwest, Mercy/Premier Health Plans, Prudential HealthCare Plan	BlueCHOICE, HealthLink, Humana Health Plan, United Healthcare of the Midwest
Mental Health Hospitalization Follow-up Rate	BlueCHOICE, Group Health Plan, Health Partners of the Midwest, Mercy/Premier Health Plans, Prudential HealthCare Plan	Humana Health Plan, United Healthcare of the Midwest
Mental Health Readmission Rate		Group Health Plan, United Healthcare of the Midwest
Overall Member Satisfaction Plan Rating	Mercy/Premier Health Plans, United Healthcare of the Midwest HMO	BlueCHOICE, Group Health Plan POS, HealthLink HMO, Humana Health Plan, Prudential POS
Rate of Advising Smokers to Quit	Health Partners of the Midwest	BlueCHOICE

Medicare Managed Care Plans with High or Low Indicators

	Central Region	
	Managed Care Plans with	
Indicator	Higher than Average Performance	Lower than Average Performance
Breast Cancer Screening Rate		
Diabetic Eye Exam Rate		
Mental Health Hospitalization Follow-up Rate		
Mental Health Readmission Rate		
Overall Member Satisfaction Rating		

NO PLANS AVAILABLE

Medicaid Managed Care Plans with High or Low Indicators

	Central Region	
	Managed Care Plans with	
Indicator	Higher than Average Performance	Lower than Average Performance
Rate of Prenatal Care in First Trimester		
Cesarean Section Rate		HealthCare USA of Missouri
Vaginal Birth after Cesarean Rate (VBAC)	HealthCare USA of Missouri	
Cervical Cancer Screening Rate		HealthCare USA of Missouri
Childhood Immunization Rate		HealthCare USA of Missouri
Members Satisfaction Plan Rating		

What Do Managed Care Plans Look Like?

Plan Type	Plan Name	Date Business Started in Missouri	Missouri Enrollment	Areas of Region Served	Region Market Share
Commercial	BlueCHOICE[1]	1987	109,759	Central, North Central, South Central	11.7%
	Group Health Plan[1]	1985	97,246	Central	1.4%
	HealthLink HMO[1]	1993	19,401	Central	5.1%
	Health Partners of the Midwest	1988	48,791	Central	2.6%
	Humana Health Plan	1987	58,759	Central, South Central	11.6%
	Mercy/Premier Health Plans	1995	78,345	Central, North Central, South Central	9.1%
	Missouri Advantage	1996	5,452	Central	2.3%
	Prudential HealthCare Plan[1]	1986	44,094	Central	0.3%
	United HealthCare of the Midwest[1]	1985	478,042	Central, South Cental	55.9%
Medicare	(no plans available)				
Medicaid	HealthCare USA of Missouri	1995	77,475	Central	100%

These plans were licensed to do business in Missouri during 1997.

DEFINITIONS

The following definitions are provided to assist the reader in understanding the data on pages 8-9.

Date Business Started in Missouri

This is the date on which the plan was open for business. It indicates the level of experience of the plan, measured in time, in providing managed care services. There are strengths and weaknesses that may be found in both mature plans and newer plans. For example, more mature plans may be likely to have resolved issues and concerns that newer plans are just addressing. On the other hand a newer plan may be concerned with gaining enrollees so that it may be extremely responsive to consumer requests.

Missouri Enrollment

These figures indicate how many Missourians were enrolled in a particular type of managed care product in 1997. There are strengths and limitations relative to a plan's size. A large plan may be able to spread the risk of high medical expenses from a few very sick members across a more extensive population so they do not adversely impact the plan's overall financial viability. On the other hand, smaller plans may be able to respond more quickly to consumer requests.

Areas of Region Served

Some managed care plans are available only in specified counties or areas. This list will tell you the general areas of this region which are served by the various plans.

Region Market Share

This indicates the percentage of potential enrollees by type of plan who have enrolled in a managed care plan in this region. It provides an indication of both plan size and the experience in meeting the needs of a specific size population. It also provides an indication of the population size over which plan risk is spread for medical services.

[1] Plan includes HMO and POS products

Performance Level
● = High ◓ = Average ○ = Low
NA= not applicable
NR= no report of data

Plan Type	Medical Expense Ratio	Admin. Expense/ Total Revenue	Days in Unpaid Claims	Accreditation Status	Disenrollment	Missouri Complaint Index
Commercial	94	◓	◓	none	30%	○
	89	●	●	NCQA	11%	◓
	87	●	●	none	50%	○
	90	◓	○	none	16%	●
	85	●	●	NCQA	NA	●
	101	◓	○	none	17%	●
	85	◓	○	none	NR	◓
	89	◓	◓	NCQA	NA	●
	89	●	○	URAC	25%	○
Medicare						
Medicaid	90	●	○	NR	NA	●

The numbers used to calculate financial indicators and the Complaint Index were provided by the Missouri Department of Insurance. Data were averaged for the three years of 1995, 1996 and 1997. These are only representative financial indicators and do not represent all indicators used to determine financial stability. The selection and usage of a limited range of indicators should not be the only financial information used for comparison purposes for health maintenance organizations. Each financial indicator may vary significantly dependent on the development stage, asset structure or other factors unique to each health maintenance organization.

Medical Expense Ratio

This is the percentage of total premiums and related revenues that covers total medical and hospital expenses. A ratio that is too high can mean the plan may not be making sufficient profit to stay in business. Too low a ratio may mean the plan is not spending enough revenues on medical and hospital expenses. A ratio between 85% and 95% should be considered typical, although a plan that is just starting up may have a lower ratio.

Administrative Expenses/Total Revenue

This is the percentage of total income used for administrative overhead. It is an indicator of "efficiency." Plans with administrative expenses less then 15% are shown as high performance (●). Plans with administrative expenses between 15% and 29% are shown as average (◓) and plans with administrative expenses of 30% or more are shown as low performance (○).

Days in Unpaid Claims

This indicator tells how long it takes to pay benefits and other bills. It is important because it tells how long providers have to wait to get paid. High performance (●) is less than 45 days, average performance (◓) is 45-59 days, low performance (○) is 60 days or more.

Accreditation Status

Missouri managed care plans may voluntarily seek accreditation and qualify for several types of accreditation, indicating that they meet national accreditation standards from the following organizations: National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC). A plan that is not accredited is listed as "none." A plan that has not reported is listed as "NR."

Disenrollment

This is the percentage of all managed care plan enrollees who have "left" the plan for whatever reason. This measure serves as a measure of stability of membership in the health plan. It does not differentiate between members who leave because of dissatisfaction and members who leave for other reasons, so it should not be used as a proxy for dissatisfaction.

Missouri Complaint Index

The complaint index measures how many consumer complaints the Missouri Department of Insurance has received the past three years relative to the amount of business a specific company writes in Missouri. Plans with a low number of complaints are shown as high performance (●), average number of complaints (◓), and high number of complaints (○).

Commercial Quality Indicator Definitions

The following definitions have been modified to provide concise yet professionally accurate definitions. For in-depth definitions and data collection methods please refer to the NCQA publication listed at the end of this report.

Prenatal Care in First Trimester:

the percentage of women who delivered a live baby who had a prenatal visit(s) at the appropriate time. Studies indicate that women who had a prenatal care visit during the first three months of their pregnancy have better birth outcomes. One of the goals of *Healthy People 2000* is to increase to at least 90% the proportion of all pregnant women who receive care in the first trimester of pregnancy.

Cesarean Section Rate:

the rate at which women who have delivered a live baby do so through a surgical procedure referred to as a 'cesarean section.' Cesarean section deliveries are major surgery. They require a longer hospital stay for mother and baby, a longer recuperation time, result in more infections and, of course, have higher costs. This is a quality indicator that shows the plan is performing better when it has a lower rate. A national public health goal is to reduce the cesarean delivery rate to no more than 15 per 100 deliveries by the year 2000.

Vaginal Birth after Cesarean Rate (VBAC):

the rate at which women who have had a previous cesarian section give birth vaginally. When medically possible, vaginal deliveries are preferable to cesarean sections for many reasons. Women who have vaginal deliveries have a shorter hospital stay, a shorter recuperation time, fewer infections and significantly lower costs. Studies indicate it is safe and appropriate for most women who have had a cesarean section to have later deliveries vaginally. This does not apply to all women. So, this is something you need to discuss with your doctor.

Breast Cancer Screening:

a method to identify possible breast cancer in a healthy population at the earliest possible time. It is accomplished by screening services that include mammography (an x-ray of the breast) and a clinical breast examination (CBE) where the provider feels the breast for suspicious lumps. This indicator measures the percentage of women age 52 through 69 years who had a mammogram during the reporting year or the preceding year. Women should consult with their primary care provider to determine the right time interval for their individual screening, based on their family history and other risk factors.

Diabetic Eye Exam:

the annual rate of eye examinations for all known diabetic enrollees by a qualified eye care professional. One of the complications of diabetes is blindness. Fortunately, early detection and treatment can reduce eye problems in those with diabetes and avoid needless blindness. National guidelines recommend annual eye exams for diabetic patients.

Mental Health Hospitalization Follow-up:

the percentage of members hospitalized for selected mental health disorders who were seen on an ambulatory basis or were in day/night treatment with a mental health provider within 30 days of discharge.

Mental Health Readmission:

the annual rate at which enrollees hospitalized for mental health disorders are readmitted within 365 days of hospitalization for selected mental health disorders. If appropriate care is provided, readmission rates for the same illness should be low.

Rate of Advising Smokers to Quit:

the rate at which either current smokers or recent quitters seen by a managed care provider during the reporting year were advised to quit smoking. Cigarette smoking is the most preventable cause of premature illness and death accounting for one in every six deaths. There is substantial evidence that when a physician advises a patient of the health risks of smoking and to quit smoking, smokers are likely to quit. Therefore, it is vital that primary care providers continue to advise smokers to quit. One of the goals of *Healthy People 2000* is to increase to at least 75% the proportion of primary care providers who routinely counsel patients about tobacco use cessation.

How Satisfied Members Are With Their Managed Care Plan

A survey, developed by NCQA, was conducted to determine consumers' experience with each managed care plan. The chart on page 13 lists the indicators, or measures. The following questions were asked of managed care plan members to determine the extent and level of satisfaction with the managed care plan.

Quality of Health Care Services

Thinking about your own health care and the services you received from your plan over the last 12 months, how would you rate the following?

Satisfaction With the Number of Doctors

• Were there enough doctors in the plan for you to choose from? A wide choice of physicians should have a positive effect on member satisfaction.

Ease of Making Appointments

• How easy was it for you to make appointments for your medical care by phone? The ease with which members have access to care by their physician could help prevent medical problems.

Getting the Care You Need

Have any of the following been a problem for you in arranging for your medical care in the last 12 months? If so, how much of a problem?

Satisfaction With the Care You Received

• Have you had difficulty receiving care you and your doctor believed was necessary? Difficulties here might indicate management problems within the plan.

No Delay Waiting for Approvals

• Have there been delays in your medical care while you waited for approval by your health plan? Members with chronic or emergency conditions can be well-served if this shows a high satisfactory rate.

Satisfaction With Referral to Specialists

• Has there been a problem in getting a referral to a specialist you wanted to see? If a treatment plan includes a referral to a specialist, members should not have a problem receiving this type of appointment.

Member Satisfaction

Satisfaction With Plan

• All things considered, how satisfied are you with your current health plan? Many factors such as the services offered by the plan, the quality of care provided by the plan and the cost of the plan will control a member's overall feeling of satisfaction.

Plan Recommendation

• Would you recommend your current health plan to your family or friends if they needed care?

Commercial Managed Care Plans

Performance

Performance Level
● = High ◓ = Average ○ = Low
NA= not applicable
NR= no report of data
UNK= unknown

	Rate of Prenatal Care in First Trimester	Cesarean Section Rate	VBAC Rate	Breast Cancer Screening Rate	Diabetic Eye Exam Rate	Mental Health Hospitalization Follow-up Rate	Mental Health Readmission Rate	Rate of Advising Smokers to Quit
BlueCHOICE	●	○	◓	○	○	●	◓	○
Group Health Plan	●	○	◓	●	●	●	○	◓
HealthLink HMO	●	◓	NA	◓	○	◓	NA	◓
Health Partners of the Midwest	NR	NR	NR	◓	●	●	◓	●
Humana Health Plan	●	◓	◓	◓	○	○	NA	◓
Mercy/Premier Health Plans	●	●	NA	◓	●	●	NA	◓
Missouri Advantage	NA	●	NA	NA	NA	NA	NA	NA
Prudential HealthCare Plan	●	◓	◓	●	●	●	NA	◓
United HealthCare of the Midwest	●	○	◓	◓	○	○	○	◓
Statewide Managed Care Average:	95%	21%	28%	66%	28%	57%	10%	66%
Statewide Non-Managed Care Average:	89%	21%	30%	UNK	UNK	UNK	UNK	UNK
National Managed Care Average[1]:	83%	21%	UNK	71%	39%	67%	UNK	64%
National Goal:	90%	15%	NONE	NONE	NONE	NONE	NONE	75%

How We Figured the Summary Scores for Statewide Performance and Member Satisfaction Levels:

"High," "Average," and "Low" scores were assigned to each item on the chart on this page and the following page based on the results of a statistical "test of significance." Such a test is used to help determine whether the differences we see between two rates is due simply to chance or represents a meaningful difference. Each plan's pregnancy-related rates were compared with the state rates. The other indicators' rates were compared with the statewide managed care rates.

For each indicator, results are divided into three categories based on tests of statistical significance. A filled dot (●) under one of the areas indicates managed care plans with better than average performance. An open dot (○) indicates lower than average performance. A half-filled dot (◓) indicates average performance. An **NA** indicates results were not reported due to small numbers, an **NR** indicates no report of audited data by health plan. Plans were required to submit audited data. If a plan submitted data that were not audited, the data may not be comparable to other plans and therefore was not accepted. The actual plan rates and methods used to test for statistical significance are available in the Managed Care Technical Guide.

Definitions for these indicators are on page 10.

[1] Based upon data submitted to NCQA. Not all managed care plans provide data to NCQA.

Satisfaction Level
● = High ◓ = Average ○ = Low
NA= not applicable
NR= no report of data
UNK= unknown

	Satisfaction With Number of Doctors		Ease of Making Appointments		Satisfaction With Care Received		No Delay in Approvals		Satisfaction With Referrals to Specialists		How Satisfied Are You With Plan		Plan Recommendation	
	HMO	POS	HMO	POS	HMO	POS	HMO	POS	HMO	POS	HMO	POS	HMO	POS
BlueCHOICE	◓	○	◓	◓	◓	◓	◓	○	○	○	○	○	○	○
Group Health Plan	○	○	◓	○	○	○	○	○	◓	○	◓	○	◓	○
HealthLink HMO	◓	○	◓	○	○	◓	○	◓	○	○	◓	○	●	◓
Health Partners of the Midwest	●	NA	◓	NA	◓	NA	◓	NA	◓	NA	◓	NA	●	NA
Humana Health Plan	○	NA	◓	NA	◓	NA	○	NA	◓	NA	○	NA	◓	NA
Mercy/Premier Health Plans	◓	NA	◓	NA	●	NA	●	NA	◓	NA	●	NA	●	NA
Missouri Advantage	◓	NA	◓	NA	◓	NA	◓	NA	◓	NA	◓	NA	◓	NA
Prudential HealthCare Plan	○	○	◓	○	○	○	○	○	◓	○	◓	○	◓	◓
United HealthCare of the Midwest	●	●	●	●	◓	◓	◓	●	●	●	●	◓	●	◓
Statewide Managed Care Average:	39%		52%		85%		84%		82%		58%		84%	
National Managed Care Average[1]:	43%		54%		86%		83%		82%		57%		UNK	

Quality of Health Care Services

Thinking about your own health care and the services you received from your plan over the last 12 months, how would you rate the following?

- **Number of Doctors**
- **Ease of Making Appointments**

Responses could be checked on a five-point scale that ranged from "Poor" to "Excellent." Members who rated the plan as "Very Good" or "Excellent" were used to figure the rates for these indicators.

Getting the Care You Need

Have any of the following been a problem for you in arranging for your medical care in the last 12 months? If so, how much of a problem?

- **Difficulty Receiving Care**
- **Delays Waiting for Approval**
- **Specialist Referrals**

Response categories for these questions were: Yes, a big problem; Yes, a small problem; and No, not a problem. The rates shown in this column are the members who had no problem getting the care they needed in each of these areas.

Member Satisfaction

- **Satisfaction With Plan**

All things considered, how satisfied are you with your current health plan?

Members who indicated they were "Completely" or "Very" satisfied with their current health plan were grouped for this indicator.

- **Plan Recommendation**

Would you recommend your current health plan to your family or friends if they needed care?

The top two levels of recommendation, which were "definitely" and "probably yes," were combined to figure this rating.

Medicare Managed Care Plans

Performance

Performance Level
● = High ◓ = Average ○ = Low
NA= not applicable
NR= no report of data
UNK= unknown

	Breast Cancer Screening Rate	Diabetic Eye Exam Rate	Mental Health Hospitalization Follow-up Rate	Mental Health Readmission Rate
NO PLANS AVAILABLE				
Statewide Managed Care Average:	68%	42%	50%	21%
National Managed Care Average[1]:	71%	39%	UNK	UNK

How We Figured the Summary Scores for Statewide Performance and Member Satisfaction Levels:

"High," "Average" and "Low" scores were assigned to each item on the chart on this page and the following page based on the results of a statistical "test of significance." Such a test is used to help determine whether the differences we see between two rates is due simply to chance or represents a meaningful difference. The indicators were compared with the statewide managed care rate.

For each indicator, results are divided into three categories based on tests of statistical significance. A filled dot (●) under one of the areas indicates managed care plans with a performance higher than the statewide managed care average. An open dot (○) indicates lower than average performance. A half-filled dot (◓) indicates average performance. An **NA** indicates results were not reported due to small numbers; an **NR** indicates no report of data by health plan. The actual plan rates and methods used to test for statistical significance are available in the Managed Care Technical Guide.

Indicator Definitions

Breast Cancer Screening:

a method to identify possible breast cancer in a healthy population at the earliest possible time. It is accomplished by screening services that include mammography (an x-ray of the breast) and a clinical breast examination (CBE) where the provider feels the breast for suspicious lumps. This indicator measures the percentage of women age 52 through 69 years who had a mammogram during the reporting year or the preceding year. Women should consult with their primary care provider to determine the right time interval for their individual screening, based on their family history and other risk factors.

Diabetic Eye Exam Rate:

the annual rate of eye examinations for all known diabetic enrollees by a qualified eye care professional. One of the complications of diabetes is blindness. Fortunately, early detection and treatment can reduce eye problems in those with diabetes and avoid needless blindness. National guidelines recommend annual eye exams for diabetic patients.

Mental Health Hospitalization Follow-up:

the percentage of members hospitalized for selected mental health disorders and who were seen on an ambulatory basis or were in day/night treatment with a mental health provider within 30 days of discharge.

Mental Health Readmission:

the annual rate at which enrollees hospitalized for mental health disorders are readmitted within 365 days of hospitalization for selected mental health disorders. If appropriate care is provided, readmission rates for the same illness should be low.

[1] Based upon data submitted to NCQA. Not all managed care plans provide data to NCQA.

Satisfaction Level
● = High ◓ = Average ○ = Low
NA= not applicable
NR= no report of data

	Doctors Who Communicate Well	Getting Referrals to Specialists	Overall Rating of Care Received	Overall Plan Rating
NO PLANS AVAILABLE				
Statewide Managed Care Average:	72%	92%	48%	51%

Medicare managed care plans that were not in effect on January 1, 1996, are not part of HFCA's national sample of Medicare member satisfaction. No data are available for these plans.

The following questions were asked of approximately 1,860 non-institutionalized Medicare beneficiaries enrolled in managed care plans in a survey to determine the extent and level of satisfaction with the managed care plan, its providers and the care received.

Data reported comes from those managed care plan members who saw a provider in the last year and responded to this survey.

Doctors Who Communicate Well

In the last six months, how often did doctors or other health care professionals *listen carefully to you?*

In the last six months, how often did doctors or other health care professionals *explain things* in a way you could understand?

In the last six months, how often did doctors or other health care professionals show *respect for what you had to say?*

In the last six months, how often did doctors or other health care professionals *spend enough time* with you?

Specialist Referrals

In the last six months, was it always easy to get a referral when you needed one?

Overall Rating of Care Received

We want to know your rating of all your health care in the last six months from *all doctors and other health care professionals.* Use any number on a scale from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible. How would you rate all your health care?

Overall Plan Rating

We want to know your rating of all your experience with *your health plan.* Use any number on a scale from *0 to 10* where 0 is the worst health insurance plan and 10 is the best health insurance plan possible. How would you rate your health insurance plan *now*?

Medicaid Managed Care Plans

Performance

Performance Level
● = High ◓ = Average ○ = Low
NA= not applicable
NR= no report of data
UNK= unknown

	Rate of Prenatal Care in First Trimester	Cesarean Section Rate	VBAC Rate	Cervical Cancer Screening Rate	Childhood Immunization Rate
HealthCare USA of Missouri	◓	○	○	○	○
Statewide Managed Care Average:	68%	16%	36%	33%	7%
Statewide Non-Managed Care Average:	74%	21%	28%	UNK	UNK
National Goal:	90%	15%	NONE	85%	90%

Indicator Definitions

The following definitions have been modified to provide concise yet professionally accurate definitions. For in-depth definitions and data collection methods please refer to the NCQA publication listed at the end of this report.

How We Figured the Summary Scores for Statewide Performance and Member Satisfaction Levels:

"High," "Average" and "Low" scores were assigned to each item on the chart on this page and the following page based on the results of a statistical "test of significance." Such a test is used to help determine whether the differences we see between two rates is due simply to chance or represents a meaningful difference. The indicators were compared with the statewide managed care rates. Data reported comes from those managed care plan members who saw a provider in the last year and responded to this survey.

For each indicator results are divided into three categories based on tests of statistical significance. A filled dot (●) under one of the areas indicates managed care plans with higher than average performance. An open dot (○) indicates lower than average performance. A half-filled dot (◓) indicates average performance. An **NA** indicates results were not reported due to small numbers, an **NR** indicates no report of audited data by health plan. Plans were required to submit audited data. If a plan submitted data that were not audited, the data may not be comparable to other plans and therefore was not accepted. The actual plan rates and methods used to test for statistical significance are available in the Managed Care Technical Guide.

Prenatal Care in First Trimester:

the percentage of women who delivered a live baby who had a prenatal visit(s) at the appropriate time. Studies indicate that women who had a prenatal care visit during the first three months of their pregnancy have better birth outcomes. One of the goals of *Healthy People 2000* is to increase to at least 90% the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy.

Cesarean Section Rate:

the rate at which women who have delivered a live baby do so through a surgical procedure referred to as a 'cesarean section.' Cesarean section deliveries are major surgery. They require a longer hospital stay for mother and baby, a longer recuperation time, result in more infections and, of course, have higher costs. This is a quality indicator that shows the plan is performing better when it has a lower rate. A national public health goal is to reduce the cesarean delivery rate to no more than 15 per 100 deliveries by the year 2000.

Vaginal Birth after Cesarean Rate (VBAC):

the rate at which women who have had a previous cesarian section give birth vaginally. When medically possible, vaginal deliveries are preferable to cesarean sections for many reasons. Women who have vaginal deliveries have a shorter hospital stay, a shorter recuperation time, fewer infections and significantly lower costs. Studies indicate it is safe and appropriate for most women who have had a cesarean section to have later deliveries vaginally. This does not apply to all women. So, this is something you need to discuss with your doctor.

Cervical Cancer Screening Rate:

the percentage of women who received one or more Pap tests during the reporting year or the two years prior to the reporting year. Early detection for many cancers is vital for treatment and cure as it responds well to early detection and treatment.

Childhood Immunization Rate:

the percentage of children who turned two years old during 1997 who had received all childhood immunizations. All plans were rated low performance because none of the plans reported rates close to the statewide immunization rate of 78% for all children. The low Medicaid managed care rates are the result of a combination of factors. Managed care plans did not have complete data bases on all immunizations provided to their children and they did not adequately check physician records to improve their data.

Member Satisfaction

Satisfaction Level
● = High ◓ = Average ○ = Low
NA= not applicable
NR= no report of data
UNK= unknown

	Satisfaction With Number of Doctors	Ease of Making Appointments	Satisfaction With Care Received	No Delay in Approvals	Satisfaction With Referrals to Specialists	How Satisfied Are You With Plan	Plan Recommendation
HealthCare USA of Missouri	○	◓	◓	◓	◓	◓	◓
Statewide Managed Care Average:	37%	49%	83%	77%	77%	46%	85%

The following questions were part of a survey of members of Medicaid managed care plans conducted by the Division of Medical Services, Department of Social Services. It measured the extent and level of satisfaction with the managed care plan, its providers and the care received. Response to the survey was limited, and tests of statistical significance may be unreliable. Use this information with caution.

Quality of Health Care Services

Thinking about your own health care and the services you received from your plan over the last 12 months, how would you rate the following?

- **Number of Doctors**
- **Ease of Making Appointments**

Responses could be checked on a five-point scale that ranged from "Poor" to "Excellent." Members who rated the plan as "Very Good" or "Excellent" were used to figure the rates for these indictors.

Getting the Care You Need

Have any of the following been a problem for you in arranging for your medical care in the last 12 months? If so, how much of a problem?

- **Difficulty Receiving Care**
- **Delays Waiting for Approval**
- **Specialist Referrals**

Response categories for these questions were: Yes, a big problem; Yes, a small problem; and No, not a problem. The rates shown in this column are the members who had no problem getting the care they needed in each of these areas.

Member Satisfaction

Member satisfaction data comes from those managed care plan members who saw a provider in the last year and responded to this survey.

- **Satisfaction With Plan**

All things considered, how satisfied are you with your current health plan?

Members who indicated they were "Completely" or "Very" satisfied with their current health plan were grouped for this indicator.

- **Plan Recommendation**

Would you recommend your current health plan to your family or friends if they needed care?

The top two levels of recommendation, which were "definitely" and "probably yes," were combined to figure this rating.

A managed care plan should provide you with a member handbook, a subscriber contract, a listing of doctors and hospitals under contract with the plan and other information to help you select the right plan for you and your family. Beside the information provided in this guide, you should also ask the plan the following types of questions:

Choosing a Managed Care Plan

1. Is my regular practitioner a part of the managed care plan's network? Will I be able to see the same primary care doctor all of the time?

2. If I am under the care of a specialist, is he or she part of the plan's network? Is it possible to receive services from a specialist not affiliated with my managed care plan? Will the managed care plan make exceptions?

3. What services does the plan cover? What preventive services does the plan offer (e.g. physical exams, immunizations)?

4. How and where do I obtain after-hours care?

5. How do I receive care if I am out of town or in another state?

6. What are the plan's policies relating to pre-existing conditions?

7. How are complaints or grievances handled?

8. Does the plan require prior authorization for specialty care? What is the procedure?

9. Does the plan offer translation services if needed?

10. What are my premium costs? Co-payments? Deductibles?

11. If I am covered by a second insurance policy, will the plan bill the second insurance policy?

12. What specialized hospitals are in the plan's network?

13. What are the pharmacy benefits? Co-payments?

14. What drugs will the managed care plan pay for?

This brochure provides a variety of types of information about how satisfied managed care members were with their plan, as well as some HEDIS® performance measures. It provides important information by which you can review your managed care options. You are encouraged to seek additional information about the plan from as many sources as possible, including your doctor, family and friends. This worksheet will help you organize the information you receive about local managed care plans.

Your Personal Worksheet

TO COMPLETE see Managed Care Plan listing Review benefit information from your employer or managed care plan.	Review the list of doctors and hospitals in the managed care plan member handbook to be sure the doctors and hospitals you prefer are available.	Review Member Handbook	Review the appropriate section of this report on commercial, Medicare or Medicaid plans.
Managed Care Plan Which managed care plans are available where you live and work?	Does this managed care plan include your primary care provider and hospital?	What is the premium?	Did this managed care plan score well based on information in this booklet?

List indicators you are evaluating.

Getting More Information

If you have concerns about your treatment or feel you have been denied health services, you may call your managed care plan. The plan will explain how to file a grievance. If you disagree with a plan's position or decision, you can file a complaint with the Missouri Department of Insurance by calling the Insurance "Hotline" at 1-800-726-7390.

Know Your Rights

Know your rights as a patient. You have the right to:

- see your primary care provider;
- urgent or after hours care for medically necessary conditions;
- make a complaint or appeal a decision made by your managed care plan;
- receive specialty care that is medically necessary;
- see your medical records;
- coverage for all emergency calls if a prudent person would have sought medical treatment under similar circumstances;
- action by managed care plan on authorizing procedures and response to complaints within specified time frames;
- access to health care providers without unreasonable distances to travel or lengthy delays;
- be informed about medical services;
- make an informed decision about proposed medical services;
- not be charged or billed by network providers for covered services that managed care plans fail to pay;
- to obtain care without plans creating financial incentives for providers to give less-than-necessary care;
- privacy and confidentiality about your medical condition; and
- a description of:

1. coverage, benefits, maximums and benefit limitations;
2. any benefit exclusions, including the definition of medical necessity used in determining coverage;
3. all requirements for treatment and service, including prior authorization;
4. utilization review (UR) policies, including when it is used, the toll-free number for UR agent, time-frames for UR decisions, the right to appeal decisions; and
5. financial responsibility for premiums, co-pays, deductibles and other charges, including charges for non-network services.

More detailed information can be found in the Revised Statutes of Missouri, Section 354.442 Statutes of Missouri Supplemental 1997.

Know Your Responsibilities

Know the rules of your managed care plan before you use medical services. You have a responsibility to:

- select a regular medical provider;
- schedule appointments and keep them, or call to cancel;
- read materials given to you and ask questions about anything you do not understand;
- make sure that you follow the rules of your managed care plan about referral to other providers before seeing other medical providers (if you see a specialist without a referral, you may have to pay the bill);
- use hospital emergency rooms, after hours and urgent care facilities for emergencies or urgent care only;
- file a grievance according to the managed care plan's procedures if payment is denied; and
- maintain your health, by eating right, exercising, getting regular check-ups, not smoking and following your doctor's instructions.

Managed Care Plans And Telephone Numbers

Advantra	(800) 755-3901
Blue-Advantage	(816) 395-2222
Blue-Advantage Plus	(800) 892-6048
Blue-Care	(816) 395-2222
Blue-CHOICE	(800) 634-4395
Blue-CHOICE Senior	(800) 634-4395
CARE PARTNERS	(314) 505-5401
CIGNA HealthCare of KS/MO	(913) 451-9839
CIGNA HealthCare of St. Louis	(314) 726-7860
Community Care Plus	(314) 454-0055
Community Health Plan	(816) 271-1247
Cox-Freeman HealthPlans	(800) 205-7665
Exclusive Healthcare	(800) 617-2871
Family Health Partners	(816) 855-1881
FirstGuard Health Plan	(816) 922-7250
Group Health Plan	(800) 755-3901
Healthcare American Plans	(800) 475-4274
Healthcare USA of Missouri	(800) 213-7792
HealthLink HMO	(800) 624-2680
HealthNet	(800) 632-4765
HealthNet Senior Excel	(800) 804-3246
HealthNet Med Missouri	(800) 858-2903
HealthNet Blue	(800) 634-4395
Health Partners of the Midwest	(800) 338-4123
Humana Health Plan	(800) 715-4862
Humana Kansas City	(800) 715-4862
Kaiser Permanente	(800) 726-5247
Mercy Health Plans	(314) 214-8100
Mercy MC+	(314) 214-8100
Missouri Advantage	(573) 659-5200
Premier Health Plans	(314) 214-8100
Principal Health Care of Kansas City	(800) 969-3343
Principal Health Care of St. Louis	(314) 434-6990
Prudential HealthCare-Kansas City	(816) 756-5588
Prudential HealthCare-St. Louis	(800) 298-7625
Prudential HealthCare Community Plan	(800) 298-7625
Total HealthCare	(816) 395-2222
Total HealthCare 65	(816) 395-2222
United HealthCare of the Midwest	(800) 627-0607

Additional Phone Numbers

CLAIM (Community Leaders Assisting the Insured of Missouri) contracted by MO Dept. of Ins. for Seniors	(800) 390-3330 or (573) 893-7900
Division of Aging Information Hotline	(800) 235-5503
Division of Medical Services	(573) 751-6922
HCFA Regional Office	(816) 426-2866
Medicaid Recipient Services	(800) 392-2161
Missouri Patient Care Review Foundation	(800) 347-1016
MO Department of Insurance Consumer Hotline	(800) 726-7390
Kansas City Office	(816) 889-2381
St. Louis Office	(314) 340-6830
Social Security Office	(800) 772-1213

WEBSITE PAGES

The following web pages may be useful:

www.health.state.mo.us

www.ncqa.org

www.ncqa.org/hedis.htm

www.ama-assn.org

www.hcfa.gov

www.hcfa.gov/medicare/mgdcar.htm

www.samhsa.gov/mc/mancare.htm

www.ahcpr.gov

www.familiesusa.org/managedcare

www.am-osteo-assn.org

www.aahp.org

References:

Healthy People 2000. Department of Health and Human Services Publication No. (PHS) 91-50212.

Missouri Health Maintenance Organization Report 1996. Missouri Department of Insurance Managed Care Section, December, 1997.

National Committee for Quality Assurance. HEDIS® 3.0/1998. Washington DC: NCQA, 1997.

U.S. Preventive Services Task Force. Guide to Clinical Preventive Services, 2nd ed. Baltimore: Williams & Wilkins, 1996.